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PLANNING AND EXECUTING A TRANSITION TO A NEWLY
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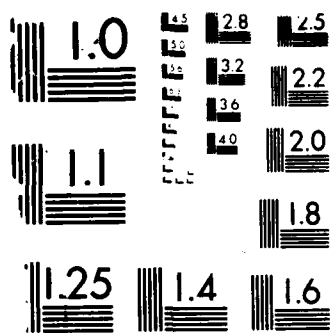
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PLANNING AND EXECUTING A TRANSITION TO A NEWLY
CONSTRUCTED MILITARY HEALTH CARE FACILITY

BY

COLONEL GEORGE E. HAMMOND, JR.

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US ARMY WAR COLLEGE, CARLISLE BARRACKS, PENNSYLVANIA

Planning for and executing a move into a new health care facility while at the same time continuing operation of an old facility is an extremely complex process. The author uses recent experience obtained during a move to a newly constructed Army hospital to provide valuable information to other military health care administrators who may be confronted with this task. The essay is an executive summary of the more detailed information contained in, Transition Planning Packet, Evans Army Community Hospital, Fort Carson, Colorado, December 1984, which was also written by the author. A copy of this document is on file with the Military History Institute, Carlisle Barracks, Pennsylvania.

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PLANNING AND EXECUTING A TRANSITION TO A NEWLY
CONSTRUCTED MILITARY HEALTH CARE FACILITY

An Individual Essay

by

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ABSTRACT

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Planning for and executing a move into a new health care facility while at the same time continuing operation of an old facility is an extremely complex process. The author uses recent experience obtained during a move to a newly constructed Army hospital to provide valuable information to other military health care administrators who may be confronted with this task. The essay is an executive summary of the more detailed information contained in, Transition Planning Packet, Evans Army Community Hospital, Fort Carson, Colorado, December 1984, which was also written by the author. A copy of this document is on file with the Military History Institute, Carlisle Barracks, Pennsylvania.

See also: Transition Planning Packet, Evans Army Community Hospital, Fort Carson, Colorado, December 1984.

PLANNING AND EXECUTING A TRANSITION TO A NEWLY CONSTRUCTED MILITARY HEALTH CARE FACILITY

PURPOSE

The purpose of this essay is to provide valuable information to military health care administrators who may be confronted with the complex task of transitioning into a newly constructed health care facility -- while at the same time continuing operation of an old health care facility.

The information contained in this essay pertains to transitional planning for all military hospitals -- but the general concepts will be of value to hospital administrators faced with this task in any sector of our society.

SCOPE

This essay will be an executive summary of the more detailed information contained in, Transitional Planning Packet, Evans Army Community Hospital, Fort Carson, Colorado, December 1984. A copy of this document will be placed on file with the Military History Institute, Carlisle Barracks, Pennsylvania.

In addition, this author intends to publish at least four additional articles covering detailed information on transitional planning, training of hospital employees, negotiating with the union on new hospital policies, and the utilization of Medical USAR personnel in support of this whole process. These articles will be on file with the American College of Health Care Executives, Chicago, Illinois.

This essay will not address two important issues that anyone planning for and implementing the transitional process should be prepared to deal with. One issue is "people problems" that surface when long term civilian employees become involved in moving to a new facility, learning new systems, and being subjected to new policies and procedures that they may not understand the rationale for. The other issue is the process of disposing of equipment furniture, and buildings left at the old facility and no longer needed for the current mission at the new facility, or for future mobilization requirements.

This author departed Ft. Carson for the Army War College almost immediately after the move to the new facility and therefore was not involved with these two important issues. However they are key to completing the transitional process and should be planned for. If I were implementing this process again I would pay more attention to the impact of the move on all hospital employees and begin an educational program early on in the transitional process. The logistics personnel assigned to Army hospitals are qualified to properly dispose of excess equipment and buildings after the move; however these personnel become intensely involved during the provisioning phase and actual move to the new facility. In the capacity of Chief Executive Officer it was this author's responsibility to ensure the post move activities were also properly planned for.

BACKGROUND INFORMATION

In order to better understand the transitional planning process required for any particular situation, one must consider

the impact of the project in question on the community and the army post.

This author will use the Ft. Carson example for the purposes of this essay.

General Description of Fort Carson:

Fort Carson is home for the 4th Infantry Division (Mechanized), an armor heavy combat force which pursues a very active training regimen in support of contingency missions. This "mountain post", as it is called, sits at the base of Cheyenne Mountain, near Pikes Peak and other scenic landmarks along the front range of the Rockies. On-post community facilities are very modern and diverse in their offerings. Schools carry students through grade nine, augmented by bus service to nearby Fountain for high school. Fort Carson has limited officer housing on the post, but this condition has proved inconsequential due to the attractive housing market in the local community.

General Description of the Area:

The Colorado Springs metropolitan area, consisting of over 350,000 people, is a progressive growing community just one hour south of Denver which is also the location of Fitzsimmons Army Medical Center and numerous civilian medical centers generally associated with the University of Colorado Medical School. Colorado Springs is generally considered to have excess civilian medical resources. Many health care providers desire to live in the area because of the desirable living conditions. The area is

also overbuilt in respect to hospital bed capacity. Most local hospitals only utilize one third to one half of their bed capacity. Approximately one-half of the 350,000 residents of Colorado Springs are eligible beneficiaries for military health care. Primary care for these military beneficiaries is provided by Ft. Carson Army Hospital, the Air Force Academy Hospital, and Peterson Air Force Base Clinic. Much of the specialty and outpatient care in excess of the capacity of the local military facilities is taken care of by CHAMPUS, or other payment modes utilizing health care resources of Colorado Springs.

Description of Old Fort Carson Hospital:

Ft. Carson operated a 174-bed fully accredited community hospital. The hospital was of mobilization design and consisted of 35 buildings constructed in 1942. The Ft. Carson Hospital offered a full range of community hospital services to all groups of beneficiaries with obstetrics, orthopedics and pediatrics accounting for the major workload. The hospital employed approximately 500 military and 500 civilian employees, including 51 physicians and numerous other health care providers. A new modern health care facility was needed in order to provide medical care to troops and other authorized beneficiaries, and for more efficient and economical operation.

Alternatives Considered:

- a. Continue the use of the existing facility.
- b. Divert patient load to other DOD health care facilities in the Colorado Springs/Denver area.
- c. Divert patient load to existing area civilian health care facilities.

- d. Reduce services to accommodate active Army personnel only.
- e. Construct a permanent hospital facility at Ft. Carson (the alternative selected)

The New Evans U.S. Army Community Hospital:

The Evans U.S. Army Community Hospital is named in honor of Specialist Four Donald W. Evans, Jr., a member of Company A, 2nd Battalion, 12th Infantry, 4th Infantry Division. Specialist Evans was awarded the Medal of Honor for action at Tri Tam, Republic of Vietnam, where he gave his life while administering medical aid to his fellow soldiers.

The hospital is comprised of two buildings separated by a glassed Commons Area. The five story Nursing Tower at the front of the hospital houses all Inpatient Nursing Units, the Operating Suite, the Delivery Suite, Nursery, Radiology, Occupational Therapy, Physical Therapy, Emergency Room, and the Nutrition Care Division. The two story Clinic Building contains all Outpatient Clinics, the Command Suite, and other administrative support functions. The Commons Area which provides the main entries into the building also houses patient service activities such as Outpatient Records, Outpatient Pharmacy, Admissions and Dispositions, Hospital Treasurer, PX, Barber shop, Chapel, Patient Administration Division, Clinical Support Division, and Patient Representative's Office.

Physical Characteristics:

Net Square Feet	298,128	
Gross Square Feet	513,378	
Total Rooms	1,398	
Operating Rooms	11	(includes 2 for Outpatient surgery)
Delivery Rooms	3	
Dental Chairs	4	
Bassinets	36	(includes 5 ICU and 5 observation)
Beds	195	(total)
Med/Surg	100	beds (two 33 and one 34 bed unit)
CCU	6	beds
ICU	6	beds
Pediatrics	19	beds
Obstetrical	32	beds
Light Care	32	beds

Specialty support systems and features incorporated into the design include:

- A nurse call system providing communication, monitoring and signaling capability from each patient location to a central console.
- A medical utility system with piped medical gases to each bed.
- A pneumatic tube system for transporting specimens, test results, medication and paperwork between stations.
- A public address system providing music throughout the hospital, including patient rooms.
- A cartlift system from central material to the operating room and delivery suite for the quick movement of sterile supplies to these areas.

Importance of Background Information:

The information provided in this section is essential to any transitional planning effort. Examples are as follows:

- a. The lack of officer housing on post and the fact that one of the best school districts in the area is located north towards

the Air Force Academy indicates that many officer personnel will continue to have their dependents seen at the Air Force Academy even if a new Army Hospital is built.

b. Excess health care capacity in the local area had been taking up the slack in the old hospital system. If transition dollars are available this excess civilian capacity may be used in case of emergency (or planned) if needed during the transition process. Because this excess capacity has been used in the past, local politics may intercede to slow or stop the new hospital project.

These are just two of many examples of how general background information may be of significance to transitional planners.

ORGANIZATION FOR HOSPITAL CONSTRUCTION AND TRANSITION

In November of 1982, construction started on a new hospital building and clinic structure. The expected cost was \$81, , with a completion date of November 1985. The actual completion date (99%) was March 1986 with an occupancy date of August 1986. The new hospital was built to the specifications of the Army Surgeon General by the Office of the Corps of Engineers. This organizational format sets up a two channel chain of command which complicates the coordination of the construction of the hospital. The Army then is confronted with a need for a management plan that permits the coordination between the Surgeon General, the Corps of Engineers, and the users of the facilities at the local post.

At the local post level, coordination with the Surgeon General's representative and the Corps of Engineers is accomplished by the Deputy Commander for Administration (DCA) at the post hospital and the Director of Engineering & Housing, Post Staff.

The Health Facilities Project Office:

The Office of the Army Surgeon General assigns to the project site a Health Facility Project Officer (HFPO) whose express purpose is that of representing the Army Medical Department during the period of construction. The HFPO is primarily concerned with all medically related construction requirements in the plans and specifications of the project. Although the HFPO is not a member of the hospital staff, he is a Medical Service Corps Officer and one of the primary advisors to the DCA during the period of construction (3 - 5 years). In addition to the HFPO, there is also assigned a nurse who normally has a degree in Health Care Administration. This individual is considered the project nurse and is titled the Nurse Methods Analyst (NMA). The NMA functions as the major resource person to the Health Facility Project Officer in the area of functional design concepts and systems development. The NMA advises and consults on all matters pertaining to patient care and looks for patient care implications on all issues to change, modify, etc the construction.

The Health Facilities Project Office is also resourced with clerical personnel, draftspersons and an NCOIC. In addition I assigned a Medical Maintenance NCO. If involved in future

projects I would also assign a logistics officer/NCO in order to develop new property books, hand receipts, etc. completely independent of the existing facility.

The Transition Coordinator:

This is an important position that fills the void between the Deputy Commander for Administration (DCA), the Health Facility Project Officer (HFPO), the Corps of Engineers and the Director of Engineering & Housing (DEH). The Transition Coordinator should be an Officer or NCO who has had experience in moving to a new facility. This person should be assigned to the new hospital project office with the specific responsibilities of representing the MEDDAC Commander and DCA's interests toward timely completion of the construction project. The construction can be accomplished on time, but if the MEDDAC does not order necessary equipment, train personnel, and make move arrangements, the move will not be completed in a timely and efficient manner. The transition coordinator must not be involved in the day-to-day activities of the old hospital. He must be future oriented and only involved in the actions necessary to move to the new facility. Unfortunately this position must come out of the MEDDAC's current resources and is not an authorized part of the Health Facility Project Office. However, the DCA is concerned on a day-to-day basis with running the current facility -- but must have a representative on a full-time basis in the new project office. The only alternative is to take it out of your "hide" -- and it's worth it in the long run.

MAJOR TRANSITIONAL TASKS

The whole transitional planning sequence is centered on identifying major transitional tasks (MTT), fixing responsibility for accomplishing these tasks, and monitoring completion of the MTT's. Most MTT's were identified by members of the current MEDDAC staff who recognized a different method of operation in the new facility that needed to be addressed before the upcoming move.

In general, a task was classified as an MTT based upon its having met one or more of the following criteria:

- a. The task would involve expenditure of funds, especially construction or transition funding.
- b. The task would potentially impact upon manpower staffing, either increasing or decreasing the requirement for same.
- c. The task would require extensive training/orientation of staff personnel from multiple elements, with such training/orientation being required prior to occupying the new hospital.
- d. The task would involve a requirement for coordination/interface among multiple MEDDAC and hospital elements, with no one element having clear-cut responsibility for exercising overall coordination/interface among the other elements.

A principal staff proponent was designated for each MTT and was responsible for:

- a. Becoming the resident expert with respect to the subject area covered by the MTT, from/to whom other staff members could obtain information, pose questions, identify problems/issues, provide recommendations, obtain planning guidance, etc.
- b. Serving as the focal point of contact within MEDDAC for coordinating the actions of all other staff members who had a contributing/supporting role in accomplishing the MTT.
- c. Developing a written MTT Action Plan which specifically identified, in chronological sequence, what must be done, by whom and by when, so as to insure accomplishment of the MTT in a timely and effective manner.

d. Monitoring the progress of each subtask associated with the MTT Action Plan; to insure that it was accomplished on schedule, was well-coordinated, and contributed to accomplishment of the overall MTT in a timely and effective manner.

e. Advising the Construction Project Group of any significant problem which may have precluded accomplishment of the MTT, and providing recommendations as to corrective/alternative courses of action.

THE CONSTRUCTION PROJECT GROUP (CGP)

An instrumental problem with all construction projects that expand over a period of years (especially true in the Federal Sector) with continuous changing staffs is the numerous proposals for changing the original plans, equipment lists, and modifying space allocations. Managing these decisions must be accomplished by an authoritative body -- in a timely manner.

The Ft. Carson MEDDAC Commander used the Construction Project Group for this purpose. It was the Commander/DCA's method of probing every and all changes to the original plan for purpose, other than personal preference of the health care provider.

The CPG was established as a formal committee by direction of the MEDDAC Commander to serve during the period of construction and transition into the new hospital, and was delegated sole authority to plan, coordinate, and implement all MEDDAC actions relating to the new hospital. Under its charter, it had sole responsibility for reviewing and approving/disapproving proposals relating to the following:

- a. Design changes
- b. Selection of equipment
- c. Development of functional systems
- d. Organizational and manpower development
- e. Relocation from the old to the new hospital

The above listing was not exhaustive in portraying the scope of the CPG's functional responsibility. In reality, it was the focal point for coordinated decision-making regarding all issues/ proposals as related to the new hospital, and was the single conduit through which recommendations relative to same were forwarded to the MEDDAC Commander for final approval.

The membership of the CPG was as follows, an asterisk (*) indicating a voting member:

- * Deputy Commander for Administration (Chairperson)
- * Deputy Commander for Clinical Services
- * Chief, Department of Nursing
- * Chief, Clinical Support Division
- * Chief, Logistics Division
- * Chief, Comptroller Division
- Health Facilities Project Officer (Executive Agent/Recorder)
- Nurse Project Officer (Executive Agent)

The two Executive Agents of the CPG were responsible for coordinating the implementation of its decisions.

Formal written minutes of each CPG meeting were prepared and forwarded, along with specific CPG recommendations and decisions, to the MEDDAC Commander for approval. Approval and/or guidance as subsequently provided by the MEDDAC Commander constituted the final decision on any given issue/proposal. When approved by the Commander, copies of CPG minutes were provided to each Department/Division/Activity Chief. In addition, approved CPG minutes were reviewed at meetings of the Transitional Planning Work Group (TPWG).

Any MEDDAC staff member had the ability to present issues/proposals to the CPG. The staff member had to coordinate the proposal with the Health Facilities Project Officer in order to get on the agenda for the next upcoming CPG meeting. The

staff member who raised an issue/proposal to the CPG was also responsible for:

a. Having thoroughly coordinated same with all other MEDDAC activities that may have been involved or have pertinent input.

b. Having identified the operational impact associated with the issue/proposal.

c. Having identified any resource requirements (manpower, funding, etc) associated with the issue/proposal.

d. Having developed specific recommendation(s) as to what needed to be done and by whom, to include any alternative courses of action which might be feasible.

e. Being prepared to cogently present the issue/proposal, and associated recommendations, at the CPG meeting.

THE TRANSITIONAL PLANNING WORK GROUP (TPWG)

The TPWG was established by the MEDDAC Commander to promote staff communication and interface in the accomplishment of transitional planning tasks, and to provide overall direction and impetus to the transitional planning effort. Its specific functional responsibilities were as follows:

a. Identify transitional planning issues which required the formulation of command positions/policies and refer to appropriate decision-making body for action and subsequent issue of planning guidance.

b. Promote the exchange of information/knowledge which would facilitate transition planning efforts and contribute to the identification of all transitional tasks which should be undertaken.

c. Identify all major transitional tasks which should be accomplished, recommending the assignment of action proponentcy, tentative target date for completion, and internal/external elements with which coordination will be required.

d. Recommend reassignment of action proponentcy, as appropriate.

e. Receive, review, and approve all plans as developed by action proponents for the accomplishment of major transitional tasks and related subtasks.

f. Monitor the progress of on-going transitional tasks and related subtasks, so as to promote their accomplishment in an effective, timely and well-coordinated manner.

g. Review the status of tasks/subtasks which were significantly behind schedule or could not be accomplished, formulating/recommending alternative solutions or approaches as appropriate.

h. Via the membership, served as a conduit for the dissemination of information to all hospital elements as to what was being done by whom to prepare for occupying and operating the new hospital.

The membership of the TPWG was approximately 35 staff members. While admittedly a large group, it ensured that all key functional activities were represented, as well as provided for an established network of staff points of contact through whom information could be disseminated concerning the status of transitional planning activities and what was being done by whom to prepare for operations in the new hospital.

The TPWG employed a standing agenda that was designed to keep all staff points of contact up to date on matters such as construction progress, change orders approved by the Construction Project Group, status of equipment lists, etc. This committee was also used as a "sounding board" for staff members who wished to present recommendations for change orders, etc to the Construction Project Group. This was a working committee that worked out the details of policies and procedures to be implemented in the new facility prior to approval by the Construction Project Group.

MAJOR TRANSITIONAL PLANNING MILESTONES

The are two most significant dates related to occupying any new hospital are:

- The first is the Beneficial Occupancy Date (BOD). This is the date when construction of the new hospital is expected to be completed and the keys for the new facility turned over to the Installation DEH.

- The second is the actual relocation to the new hospital. Relocation is completed with movement of all inpatients to the new facility and also the date when the new hospital must be fully operational.

The period between BOD and relocation is termed the Provisioning Phase. It is during this period that the MEDDAC is responsible for installing or placing significant quantities of medical and non-medical equipment in the new facility, as well as furniture, artwork, signs, plants, and a multitude of other items.

It is significant to note that how the provisioning phase is carried out is dependent on the BOD being a firm date that the contractor may be depended upon to complete the project and turn the keys over to the Installation DEH. If BOD slips and the contract is not completed as planned, provisions must be made for storage of incoming equipment and furniture or slipping the delivery dates to correspond to the new BOD. This is a monumental problem that must be planned for. Contracts are seldom completed on time due to labor and/or weather problems and the provisioning phase must be adjusted accordingly.

In addition, all major transitional tasks (MTT's) are tied in some fashion to BOD and/or the Provisioning Phase. Each time BOD changes, MTT's must be adjusted accordingly. You must also

be prepared to adjust MTT's to early completion -- if the contractor finishes early. This is the most time sensitive part of the transition process and must be monitored constantly by the Engineers and the MEDDAC.

SCHEMATIC DEPICTING WAYS FOR ISSUES/PROBLEMS
TO BE SURFACED FOR RESOLUTION

Relocation of a functioning hospital from an old facility into a new one, with no break in continuity of operations, is a complicated undertaking involving a multitude of preparatory actions. Many of these actions must be undertaken far in advance in order to provide enough lead-time for necessary coordination to be effected, funding to be programmed, equipment to be procured, etc. It is imperative that the planning effort serves to identify issues/problems in sufficient time for an orderly plan of action to be developed which will lead to their timely and effective resolution.

Even with the best of planning efforts, not all issues/problems can be identified and resolved in advance. A major objective of the planning effort, however, should be to anticipate as many as possible, so that the number which do surface at a later date is kept to an absolute minimum.

In the multidisciplinary and organizationally complex structure of a hospital, the involvement of as many staff members as possible is key to the realization of a successful planning effort. No one individual, or even group of individuals, has the degree of expertise and experience to be cognizant of everything that needs to be done to ensure that all hospital elements are

fully prepared to occupy and effectively function in the new facility.

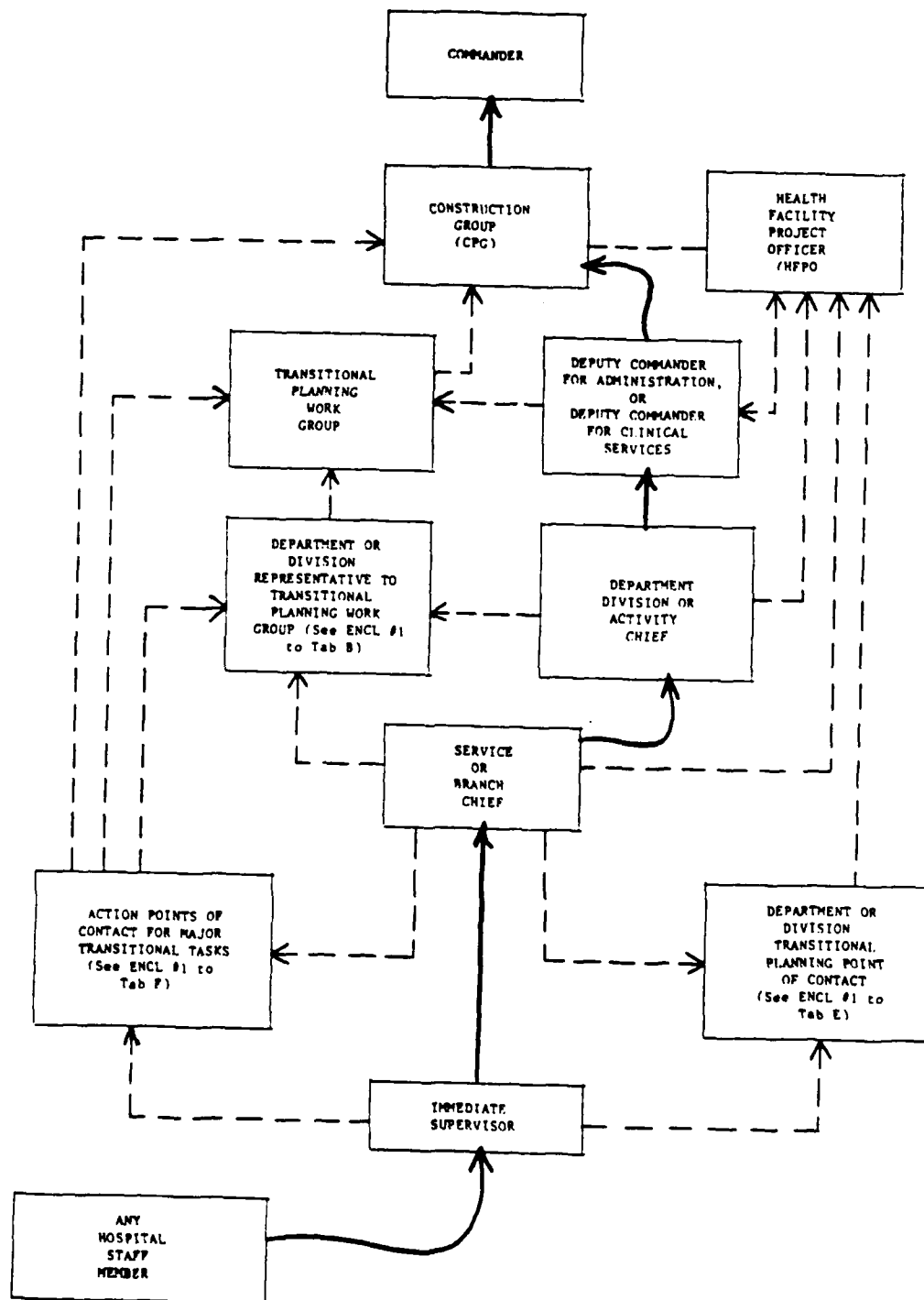
In this regard, it is essential that staff members, at all echelons within the hospital, have an understanding as to how issues/problems should be surfaced and passed up the planning chain for review and action. The schematic on the next page depicts how to get issues/problems put into "the system", so that they eventually receive the necessary attention by the appropriate planning entity which will lead to their resolution.

The primary approach for raising an issue/problem, as is perceived to impact on either relocation or on operations in the new hospital, would be to bring it to the attention of a staff member's supervisor. It would then be successively routed through those individuals/groups along the primary route as depicted by heavy arrows on the schematic, ultimately surfacing to the Construction Project Group (CPG) for consideration/recommendation and the Commander for decision approval.

Dotted arrows depict alternative approaches for surfacing issues/problems, the result being the same in that they would eventually rise to the attention of the CPG for consideration and action.

All staff members were encouraged to use this process to surface issues/problems they perceived to be relevant to the transition process -- because everyone else in the organization may have overlooked what was an obvious and extremely important planning point.

SCHEMATIC DEPICTING ISSUES/PROBLEMS RESOLUTION*



Reprinted from, Transitional Planning Packet, Evans Army Community Hospital, Fort Carson, Colorado, December 1984

USAR/ARNG STAFFING AUGMENTATION

A resource that should not be overlooked is USAR/ARNG medical personnel to augment the hospital staff during transition to the new facility. For example USAR medical equipment repairmen may be used during provisioning to install new equipment; entire USAR units used to staff the old facility while the permanently assigned staff trains in the new facility; and last but not least importantly, use of USAR Inventory Control Units to help dispose of excess equipment, furniture, and building upon completion of relocation.

USA Health Services Command is the point of contact for establishing liaison with USAR/ARNG units for this purpose. It should be noted that this process must be started early on as reserve units work 2 - 3 years out for summer camp and individual active duty for training assignments. Proper use of this resource can save the U.S. Government money and at the same time provide valuable training to USAR/ARNG Medical Units/Personnel.

TRANSITIONAL TRAINING

A major training/orientation effort is required prior to relocation to a new hospital in order to assure that hospital personnel are familiar with:

- a. How to operate new medical/non-medical equipment being procured for installation (e.g. Gamma Counter, electric beds, reproduction machines, word processors, etc).
- b. How to utilize and operate new systems that are programmed for installation (e.g., Pneumatic Tube, Facsimile Transmission, Centralized Nurse Call, Box Transport, etc).
- c. Operational procedures which have had to be rewritten to conform to a new functional layout (e.g., MASCAL Plan, Fire

Prevention/Protection Plan, Housekeeping Procedures, supply distribution, etc).

The scope of training/orientation and how many individuals are to be involved will vary, based upon each specific item of equipment, system or procedure. In some instances, as with a computer-programmed telephone system, virtually every individual in the hospital will have to be oriented. It is probable that many individuals will have to undergo considerable training/orientation, requiring a significant amount of time over a period of many weeks.

The vast majority of staff training/orientation can best be accomplished during an intensive Staff Training Period. This requires development of a comprehensive training plan which serves to schedule all training/orientation endeavors so as to preclude scheduling conflicts and prevent overload of individuals with too much information at one time.

The Plans Operations and Training Division should be tasked to coordinate development of a master transitional training schedule, which comprehensively addresses all training/orientation requirements and serves to integrate same in an orderly and well-coordinated manner.

RELOCATION

Relocation from the old hospital to the new facility is what most employees (military and civilian) see as the end result of the transitional planning process. The move normally takes the better part of a week and is accomplished in an incremental basis with movement of the inpatients being the final action.

The Ft. Carson move relocated the administrative elements during the early part of the week, with clinical and ancillary support elements being relocated later in the week. In some instances, hospital elements had to undergo split moves in order to sustain operations in the old facility while simultaneously gearing-up for operations in the new hospital -- i.e. pharmacy, lab, x-ray, and emergency room. Relocation activities will necessitate a reduction in clinical and inpatient workloads and require the postponement of some elective surgery procedures in order to reduce the number of inpatients which will require movement to the new hospital.

If dollars are available, the relocation should be contracted out to commercial movers. This procedures will minimize damage to furniture and equipment being moved as well as to the new building.

POST-LOCATION

Upon completion of the relocation to the new facility the transitional process is far from complete. Excess buildings and equipment must be disposed of in accordance with Army Regulations. Employee training and orientation must continue in order to ensure that new systems are utilized as designed rather than being circumvented by long-term employees that prefer the "old system." The public must also be educated on the new facility, new services, etc. This post-location process takes up to two years and is just as critical to transitional planning as the premove actions.

SUMMARY

Sound transitional planning is essential if a move to a new health care facility is to be executed in an effective and efficient manner. This essay merely serves as an example of how complex this process actually is. Complete articles (in depth) could be published on every area sparsely touched on in this essay. The bottom line is transitional planning and execution is vital to the successful transition to a new health care facility. Health care planners must be willing to devote time and resources to this process in order to assure that quality care is provided during this period of turmoil and transition.

END

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